TREATING PSYCHOLOGICAL TRAUMA AND PTSD

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Practical Considerations in the Treatment of PTSD: Guidelines for Practitioners

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An organismic holistic approach to the treatment of posttraumatic stress disorder (PTSD) underscores its complexity as a psychological syndrome. There is a range and diversity of traumatic stressors which are embedded in and define the nature of a particular traumatic event. The consequence of trauma is a specific intrapsychic organization of ego states and allostatic adaptation which controls symptom manifestation. As such, the practical choice of how to intervene to assist victims of trauma confronts the practitioner with decision points as to alternative interventions and psychotherapeutic approaches.

Acute interventions following a disaster, for example, may require a crisis intervention, short-term cognitive behavior therapy or a form of stress debriefing to normalize the expectable stress response sequelae (Raphael & Wilson, 2000; Horowitz, 1986). At the other end of the spectrum, complex PTSD may require intensive, prolonged psychotherapy and adjunctive pharmacotherapy to facilitate the rebuilding of shattered lives and narcissistically damaged ego states and persons (Watkins & Watkins, 1997; see our Chapter 2, this volume, for a discussion). Moreover, the trauma population being helped may require specialized treatment for PTSD depending on the characteristics which define the client (e.g., children, families, refugees, disaster victims, or persons with preexisting severe mental illness who have suffered

trauma leading to PTSD). Thus, the treatment goals for PTSD have varying objectives depending on the treatment approach for PTSD, the trauma population being served, and the nature and complexity of the posttraumatic phenomenology. One practical advantage of the organismic model of PTSD and dissociative phenomena presented in Part I of this volume is that it allows the practitioner flexibility in discerning the unique configuration of PTSD in a client and the five portals of entry (see Figures 2.2 and 2.3 in Chapter 2) by which to consider how to reach the configuration of PTSD phenomenology as a dynamic, organismic process.

As a general overview, Table 16.1 lists the 11 core treatment approaches discussed in Parts I and II and their treatment goals. For each of the treatment approaches for PTSD, the five major dimensions of PTSD derived from the allostatic tetrahedral model of PTSD are presented: (1) psychobiological (DSM-IV D criteria); (2) traumatic memory (DSM-IV B criteria); (3) avoidance, numbing, denial, and detachment (DSM-IV C criteria); (4) self-structure, ego states, and identity; and (5) PTSD and interpersonal relations.

For each of the five major dimensions of PTSD derived from the allostatic tetrahedral model is a scale which indicates the degree of relevance of each of the treatment approaches to the five dimensions of PTSD phenomenology. As Table 16.1 indicates, the scale has four rating points: (0) not applicable, (+) somewhat relevant, (++) moderately relevant, and (+++) highly relevant. By contrasting and comparing the scale points it is possible to discern areas of similarity and dissimilarity between the 11 core treatment approaches. By examining the specific treatment goals for the core approaches, both conceptual and pragmatic differences can be evaluated by the practitioner for a PTSD client. For example, acute interventions in response to critical incident events and disasters address the psychobiological components of PTSD (i.e., reduction of hyperarousal and confronting avoidance, denial, and numbing symptoms) but typically do not attempt to "treat," "intervene," or "deal" with the trauma's impact to the self-structure, ego states, or postevent interpersonal relationships (Wilson & Raphael, 2000). On the other hand, the core treatment approaches for complex PTSD and the treatment of families and couples are all highly relevant to how trauma has impacted interpersonal relations and avoidance, denial, and numbing aspects of PTSD.

Table 16.1 can be useful to the practitioner as a guide for decision making. More than one treatment approach may be indicated, depending on the configuration of the PTSD phenomenology. For example, psychopharmacological approaches may be useful to many of the treatment goals. In this regard, pharmacological approaches may be a primary modality or as one useful, and sometimes necessary, to bolster the effectiveness of a very different treatment modality, such as those discussed by Kinzie in Chapter 11, this volume, for the treatment of trauma clients from non-Western cultures.

TABLE 16.1. Treatment Approaches for PTSD and Their Goals

Core treatment approaches for PTSD	Dimensions of PTSD derived from the Tetrahedral model					Treatment goals
	I. Psychobiological	II. Traumatic memory	III. Avoidance, numbing, denial, and coping	IV. Self-structure, ego states, and identity	V. Interpersonal relations	
Psychopharmacotherapy	+++	++	+++	0	0	Facilitate normalization toward homeostasis
Psychodynamic	+	+++	+++	+++	++	Restore toward normal intrapsychic functioning
Acute interventions	++	+	++	0	0	Reestablish a normal stress response pattern
Cognitive-behavioral	++	+++	+++	++	+	Gain authority over traumatic memories
Group psychotherapy	0	+++	+++	+	+++	Facilitate normalization of PTSD responses and enhance capacity for healthy relationships
Complex PTSD	0	+++	+++	+++	++	Restore a positive self-schema of effective coping
Dual diagnosis	+++	+++	+++	++	++	Determine treatment that fosters recovery from Axis I and Axis II disorders
Cross-cultural	++	+	+++	+	++	Foster recovery within an embedded cultural framework
Children	++	+++	+++	+	+++	Foster trauma recovery to overcome interruption of normal development
Families and couples	0	++	+++	+	+++	Restore healthy attachments, relationships, and capacity for intimacy
Severe mental illness and PTSD	0	+	++	0	+++	Facilitate social reintegration and support for activities of daily living

Note. +, somewhat relevant; ++, moderately relevant; +++, highly relevant; 0, not applicable.

In the following sections, we summarize the key features of the treatment approaches as a synopsis guideline for use by practitioners. Our goal is to present the essential features of each of the 11 treatment approaches for PTSD and highlight how they may be used by the clinical practitioner who faces choice points regarding strategies and methods for treating PTSD. As such, this chapter is not intended to be directive nor comprehensive. Rather, it is to provide a framework for clinical understanding, case assessment, and empowerment of the client's recovery.

TREATMENT APPROACHES FOR PTSD AND SPECIAL TRAUMA POPULATIONS

Psychopharmacotherapy for PTSD

Pharmacotherapy is often targeted at psychobiological allostatic load in PTSD (see Friedman, Chapter 4, this volume, for a discussion). The treatment goal of various medications for PTSD is the restoration of homeostasis or normalization toward it. We should note that by definition allostasis is a changed but stable systemic and integrated stress response process within organismic functioning. The restoration of or normalization toward homeostasis reflects better and more functional levels of posttraumatic adaptation—one in which maladaptive allostatic subtypes (i.e., "repeated hits," "lack of adaptation," "prolonged stress," "inadequate response," and "combined-fusion" patterns—see Chapter 1 for a discussion) are modulated or attenuated, thus producing changed psychobiological and behavioral outcomes in which PTSD related behaviors are far less disruptive. As Table 16.1 illustrates, psychopharmacotherapy of PTSD is highly relevant to three of the five core dimensions of PTSD (i.e., psychobiological symptoms; traumatic memory; and avoidance, numbing, and denial) but has little direct relevance to restoration of self-structure, ego states, and identity or to improvement of interpersonal and object relations. Nevertheless, practitioners should consider medications for PTSD as a rational and useful adjunct to psychotherapeutic efforts within a framework of holistic organismic functioning of PTSD.

Psychodynamic Approaches to PTSD

The treatment goals of psychodynamic approaches to PTSD are to restore normal intrapsychic functioning. Such approaches place emphasis on unconscious and ego-defensive dynamics in the specific configuration of ego states in PTSD. Allostatic psychodynamic approaches to PTSD recognize that ego defenses (e.g., repression, denial, disavowal, suppression, or projection) are organized around affects which have been dysregulated by traumatic experiences. In that regard, ego-control mechanisms have been overwhelmed, ren-

dered insufficient in function, or rigidified as intrapsychic processes. Through the analysis of trauma specific transference (TST) processes (Wilson & Lindy, 1994) the therapist gains insight into how traumatized ego states are crystallized around defenses designed to ward off distressing intrusive thoughts, feelings, and images of the traumatic event. Dysregulated painful emotions caused by trauma are intrapsychically linked to cognitive processes of information processing and defensive efforts to "control" and "dose" the degree of pain attached to the memory of the trauma.

By tradition, psychodynamic approaches to the treatment of PTSD (Lindy, 1993) place emphasis on levels of conscious awareness (LCA) of dysregulated psychobiological processes. Allostasis as a form of organismic stress response does not discriminate between mind–body phenomena. Allostasis is also dysregulation of cognitive processes and therefore includes altered states of conscious awareness about traumatic material. Altered states of conscious awareness span the spectrum from dissociated mental states to hyperalert/hypervigilant cognitive functioning and include degrees of unconscious mental and behavioral activities. Arthur S. Blank, Jr. (1985), for example, listed clinically derived criteria for the "unconscious flashback" in PTSD. Similarly, Niederland (1964) described case histories which illustrate unconscious guilt and punishment themes in PTSD for Holocaust survivors. Wilson and Lindy (1994) presented case histories of PTSD patients who manifest unconscious forms of self-recrimination and self-blame, as well as unconscious suicidal ideation and unconscious shame, anger, and humiliation among victims of torture and war trauma. Considered from the perspective of allostatic dysregulations, there can be unconscious forms of behavior evident for any affect which is attached to painful traumatic memories. Hence, in TST reactions (which unfold and present in many diverse ways in psychotherapy) the critical task of the practitioner is to decode the meaning of the unconscious transference projection at that moment (i.e., *in situ*) in terms of its significance for the patient. Successful analysis of TST projections yields interpretations that identify defenses against traumatic injuries to the self. In this regard it is meaningful to speak of restoring normal intrapsychic functioning as the central goal of treatment from a psychodynamic perspective.

Acute Interventions for PTSD

Acute interventions for PTSD are those which typically occur in the immediate wake of trauma. Such interventions following a traumatic event include crisis interventions, stress debriefings, and short-term counseling (Raphael & Wilson, 2000) as well as brief cognitive-behavioral therapy (CBT) (Bryant, Harvey, Dang, Sackville, & Basten, 1998; Bryant, Sackville, Dang, Moulds, & Guthrie, 1999; Foa, Hearst-Ikeda, & Perry, 1995). Where exposure to death, dying, and human suffering is part of the traumatic event, the issue of traumatic bereavement is important and an acute intervention may be necessary

to facilitate the bereavement process. Moreover, as noted by Raphael and Dobson in Chapter 6, this volume, acute interventions may need to recognize that acute stress disorder (ASD), or symptoms thereof, may be precursors to "full-blown" PTSD at a later time. Thus, acute interventions for stress reactions, ASD or PTSD, must be adapted to address a broad spectrum of critical incident events (e.g., natural disasters, school shootings, motor vehicle accidents, bank robberies, or hostage situations) which challenge the practitioner as to how to best provide assistance. In that regard, the overall treatment goal of acute intervention procedures is to reestablish the normal stress response. Indeed, as noted by Raphael and Dobson in Chapter 6, this volume, there are at least seven primary purposes of acute posttrauma interventions: (1) providing assistance, aid, and counseling to restore homeostasis and reduce allostatic dysregulations, especially those associated with acute stress response symptoms of hyperarousal, intrusive recollections, avoidance, numbing, dissociation, denial, psychic overload, daze, disorientation, and loss of capacity for normal coping; (2) providing education as to the nature of ASD, PTSD, and expectable psychological reactions following a traumatic or highly stressful life event; (3) targeting a specific set of intervention techniques (e.g., critical incident stress debriefing or CBT) to facilitate a return to normal functioning; (4) targeting interventions to assist with the processing of the event as soon as possible in order to (5) prevent longer-term adverse effects on coping and adaptation; (6) targeting interventions to treat identifiable disorders, problems, or crises that are disruptive to healthy coping; and (7) targeting interventions to facilitate the resolution of ASD, PTSD, or other indicators of stress response syndromes with phasic stages (e.g., denial, avoidance, intrusion, working through, and cognitive restructuring).

As Table 16.1 illustrates, acute interventions are primarily directed to the psychobiological and avoidance symptoms of ASD and PTSD. Because they are acute interventions, they are *not* targeted specifically at ego-state functions or interpersonal relationships. In the broadest sense, the various types of acute interventions described by Raphael and Dobson in Chapter 6 (e.g., psychological first aid, crisis intervention, military models of debriefing, grief work, critical incident stress debriefings, or CBT) are oriented toward reestablishing the normal stress response sequence and promoting positive coping.

The concept of acute interventions focuses on early responses to trauma victims. Clinical lore and disaster research (e.g., Smith & North, 1993) provide evidence that rapid intervention following a disaster is helpful in stabilizing and normalizing the expectable stress response to overwhelming life events. However, there is a dearth of scientific studies on the short- and long-term effectiveness of early interventions. For example, Rose and Bisson (1998) reviewed six studies which employed randomized controlled trials and found only two with positive (i.e., salutary) outcomes. Moreover, two studies found negative effects of intervention. Richard A. Byrant and his colleagues

(1998, 1999) examined the treatment of ASD in several studies which compared CBT to supportive counseling for civilian trauma survivors and found that CBT was more effective than supportive counseling at follow-up intervals (i.e., 6 months or longer). Similar findings were obtained by Foa et al. (1995) for victims of sexual assault who were treated with CBT. In a study of the prevention of postrape psychopathology, Resnick, Acierno, Holmes, Kilpatrick, and Jager (1999), evaluated women who had been raped within 72 hours of the sexual assault and found that the level of distress at the time of their medical–forensic examination predicted PTSD symptomatology 6 weeks later. Further, a structured educational intervention prior to the forensic examination appeared to reduce the stress experienced during the medical procedure.

A recent comprehensive review of the literature on psychological debriefings (Raphael & Wilson, 2000) has noted that acute interventions take many forms (e.g., short-term cognitive behavioral treatments, critical incident stress debriefings, supportive counseling, community-based crisis intervention, disaster relief, or trauma action teams for civilian disasters). Further, there are not enough comparative scientific data by which to evaluate the efficacy of such procedures for the treatment of ASD or PTSD. Nevertheless, acute interventions are and will be necessary in many disaster situations (e.g., the bombing of the Oklahoma City federal building, body retrieval in natural and technological disasters), and so compassionate clinical care should "do no harm" while controlled scientific studies generate data to assess effective and noneffective interventions.

Cognitive-Behavioral Treatment for PTSD

Cognitive behavioral treatments for PTSD include a range of methods and techniques to assist patients in processing and overcoming the debilitating aspects of PTSD. At the heart of the different methods are the treatment goals of gaining authority over traumatic memories through exposure and by correcting or reframing disturbed memories, beliefs, interpretations, and emotions.

As Table 16.1 indicates, CBTs target all five of the core PTSD dimensions and have the most relevance to three areas: (1) traumatic memories; (2) avoidance, numbing, and denial; and (3) stressor impacts to the self-structure, ego states, and personal identity. Further, evidence reviewed in Chapter 7 of this volume by Zoellner, Fitzgibbons, and Foa suggests that CBT affects the psychobiological (e.g., hyperarousal) aspects of PTSD as well as the interpersonal domain of objects relations (e.g., reducing fear of others, detachment, or estrangement tendencies).

The practitioner considering the use of CBT for PTSD treatment has various therapeutic tools available in terms of targeting treatment and making assessments as to how to use one of the five portals of entry into PTSD

phenomenology reflected in the tetrahedral models presented by us in Chapter 2, this volume. The strength and elegance of CBT is that it is based on scientific principles of learning and conditioned responses to threat, fear, and other anxiety-inducing states. These techniques include (1) exposure treatments, (2) anxiety management, (3) cognitive therapy and reprocessing, (4) systematic desensitization, (5) assertiveness training, (6) biofeedback, and (7) combined techniques.

Complex PTSD: Treatment Considerations

"Complex PTSD" is a term that has been employed in the past two decades to indicate that the phenomenology of PTSD extends beyond the diagnostic criteria set forth in DSM-IV. For the practitioner, it is important to note that the logic of that diagnostic manual of the American Psychiatric Association (1994) was to create algorithms for differential diagnosis of mental disorders. The diagnostic algorithms are, in essence, the minimal set of criteria by which to define a disorder and, in turn, distinguish it from others. In terms of PTSD, researchers and clinicians have come to the realization that PTSD is *not* a unidimensional construct (see our Chapters 1 and 2, this volume, for a discussion). The concept of complex PTSD supersedes the categories of DSM-IV (i.e., behaviors, symptoms, emotional states, cognitive schemas) and defines symptoms observed among trauma survivors that extend beyond its official diagnostic criteria.

Among other authors, Judith Herman (1992) initially has proposed six dimensions of symptoms to explicate the concept of complex PTSD. These dimensions reflect the following alterations in different levels of psychological functioning and are entirely consistent with our tetrahedral allostatic model of PTSD: (1) alteration in affect regulation, (2) alteration in consciousness, (3) alteration in self-perception, (4) alteration in perception of the perpetrator or cause of traumatic injury, (5) alteration in relations with others (e.g., isolation, impulsivity), and (6) alteration in systems of meaning.

Practitioners who treat complex PTSD face a formidable task since they must decide how to support the client while dealing with multifaceted psychological symptoms at each of the five core dimensions we have listed in Table 16.1. As the table illustrates, treatment approaches to complex PTSD are highly relevant to ameliorating traumatic memories, avoidance behaviors, and damage to the self-structure, ego states, and identity. Similarly, treatment approaches to complex PTSD inevitably must address how the disorder impacts interpersonal and object relations. However, unlike the approach of the more cognitive-behavioral therapeutic techniques, the treatment of complex PTSD is not directly concerned with the psychobiological components of PTSD.

In Chapter 9, this volume, Laurie Ann Pearlman describes how the treatment of complex PTSD can be approached by constructivist self-

developmental theory (CSDT). CSDT enables the practitioner to assess cognitive schemas of the client that have been altered by experiences of interpersonal abuse, violence, and other types of trauma. Cognitive schemas pertain to the client's basic needs for security, self-esteem, and self-efficacy. In this regard, the primary treatment goal of CSDT is to restore positive self-schemas of effective coping, an objective that is most closely aligned with the goals of psychodynamic treatment approaches.

In CSDT approaches to complex PTSD, Pearlman suggests that clinical work involves six interrelated processes: (1) identifying areas of schema disruption; (2) exploring the sources of disruption; (3) exploring the meanings of the disrupted schema; (4) exploring the defensive nature of disrupted schema; (5) therapeutically challenging the disrupted schema in nurturing ways, and (6) facilitating positive life experiences which will restore a self-schema of positive coping. Consistent with the allostatic model of dysregulated organismic functioning presented in Part I of this volume, treatment of complex PTSD is directed toward ameliorating the six areas of psychological disruption identified by Herman (1992), listed above. CSDT and other approaches to the treatment of complex PTSD attempts to (1) restore organismic integrity, unity, and coherence within the self; (2) restore the client's firm belief in his or her efficacy to cope successfully with the environment; and (3) restore his or her positive worldview and belief that life is meaningful.

Issues in the Dual Diagnosis of PTSD

The issue of comorbidity in the treatment of PTSD has grown in importance as the number of scientific studies yield data by which to inform practitioners about the linkage between PTSD and other disorders. In terms of treatment goals, Table 16.1 indicates that for PTSD and dual diagnosis, the object is to facilitate recovery from Axis I and Axis II disorders. While such a treatment goal seems obvious and straightforward, the clinical nuances of case management are much more complex.

For practitioners, there are several conceptual paradigms that should be considered when they are formulating a treatment plan. First, PTSD may be the only diagnosis that requires one or more of the treatments that we have discussed throughout this book. Second, the client may have had an Axis I or Axis II psychiatric disorder prior to the development of PTSD. Third, the client may develop PTSD and another Axis I disorder as a result of trauma (e.g., major depression or substance abuse as a form of self-medication). Where substance abuse is a form of self-medication for PTSD, the client may be at significant risk for addiction, a factor that complicates the treatment plan. Fourth, as a result of trauma, the individual may have a transformation of his or her basic personality structure and manifest characteristics that may be difficult to distinguish from the features of a personality disorder (e.g., suspicion, mistrust, guardedness, isolation, irritability, and anger). Alterations in

basic personality processes induced by trauma have been referred to as PTPDs (i.e., posttraumatic personality disorder), underscoring the point that the individual experiences a life-altering traumatic event that, in essence, reshaped his or her personality traits into relatively stable patterns of behavior and coping that were not present before the trauma.

In a recent review of the literature on the epidemiology of PTSD, Breslau (1998) concluded as follows:

> Most community residents with PTSD have at least one other psychiatric disorder in their lifetime. Recent analyses that have addressed etiologic questions regarding the observed lifetime co-morbidities in PTSD have suggested several pathways: (1) PTSD increases the risk of first onset major depression and drug use disorder; (2) exposure to traumatic events per se, in the absence of PTSD, does not increase the risk of these disorders; (3) pre-existing major depression and anxiety disorder increase the vulnerability to PTSD following trauma; and (4) major depression increases the probability of exposure to trauma. (p. 26)

Epidemiological data (Breslau, 1998) show that among those with PTSD, 36.6% had lifetime major depression; 58.1% had a lifetime anxiety disorder other than PTSD; 31.2% had lifetime alcohol abuse disorder; and 21.5% had lifetime drug abuse disorder. Similar findings are summarized in Chapter 10, by McFarlane, pointing to the reality that individuals with PTSD are at risk for depression, alcohol and drug abuse, and other anxiety disorders (e.g., panic disorders; generalized anxiety disorder).

In conclusion, the treatment of comorbidity in PTSD requires combined treatment methods. As noted by Friedman (2000), "clinicians most commonly add pharmacotherapy to individual and group therapy—drug treatment not only ameliorates psychobiological abnormalities associated with PTSD, but may provide sufficient symptom reduction for clients to participate in [trauma-focused treatment]" (p. 34).

Cross-Cultural Treatments for PTSD

In Chapter 11, Kinzie presents a clinical guideline for optimal cross-cultural treatment of PTSD. As Table 16.1 illustrates, we have formulated the treatment goal as that of fostering recovery within an embedded cultural framework. This treatment objective expresses the view that an understanding of cultural differences is important when a clinician is treating a client from a non-Western culture. Culture represents the internalization of values, customs, mores, and culturally rooted beliefs as well as "rules" pertaining to social interaction and self-presentation. As discussed by Friedman in Chapter 4, this volume, recent research publications (e.g., Marsella, Friedman, Gerrity & Scurfield, 1996; Kinzie, 1988, 1993; Wilson, 1989) have underscored the wide-range of cultural differences that influence how the patient processes

traumatic memories and his or her capacity and willingness to form a trusting therapeutic alliance. So how do practitioners address the critical questions of cultural diversity in the treatment of PTSD?

Kinzie (see Chapter 11, this volume) and his associates at the University of Oregon Health Sciences Center have had nearly two decades of experience in working with culturally diverse populations with PTSD (e.g., Vietnamese, Cambodians, Laotians, Thais, and Congolese). Based on the need to provide the best possible service to these populations, Kinzie and his colleagues have evolved a multicultural treatment program that grew out of the need to address the spectrum of psychiatric disorders in which their patients had suffered because of severe trauma. As Table 16.1 indicates, of the five core dimensions of PTSD, cross-cultural treatment approaches primarily target the psychobiological aspects and the avoidance, denial, and numbing components of posttraumatic adaptation. However, the targeting of these symptom clusters is done with medications and psychoeducational techniques which recognize the importance of fostering recovery within an *embedded cultural framework.* Stated differently, in order to be effective, the therapist must know how to "step into the culture" of the client while at the same time suspending his or her own culturally shaped beliefs and values. Clearly, this is a skill that requires training, experience, and a capacity for sustained empathic atunement (Wilson & Lindy, 1994).

As a capsule summary, we have condensed the elements of the cross-cultural treatment of PTSD proposed Kinzie in Chapter 11 as follows:

- The treatment of comorbidity is paramount. Many cross-cultural clients present with a dual diagnosis and complex PTSD.
- Interpretations of bilingual staff members are important to treatment goals and understanding cultural differences.
- Easy access to the program without bureaucratic hassle is important to achieve acceptance and regular utilization of the service by cross-cultural clients.
- Acceptance of the program by the refugee, ethnic, or minority client is important to credibility with the target population.
- The program should have links to other social and medical services that are readily accessible.
- Medical (i.e., physical) and psychological needs should be carefully evaluated. Special sensitivity may be required for populations who have been physically injured or tortured by perpetrators. Since physicians assist in the torture process in some countries, posttraumatic physical examinations may be very difficult. The mere presence of a physician may trigger traumatic memories (Agger & Jensen, 1993; Juhler, 1993).
- Patients should be given opportunities to provide feedback to the program staff regarding the quality and standards of care.

- The staff needs to understand multicultural diversity and to have a broad base of competence when working with refugee or minority populations.

The development of a treatment program for culturally diverse clients with PTSD who may also have a dual diagnosis is not an easy task. It should not come as a surprise that the treatment process itself requires innovation, flexibility, and a knowledge of how to best promote recovery within an embedded cultural framework. In Chapter 11, this volume, Kinzie highlights some of the primary concerns, which include the following: (1) establishment of safety; (2) continuity of care; (3) obtaining a complete trauma history; (4) sensitivity as to the issue of when to "open up" the trauma story or when to let it remain "sealed over"; and (5) maintenance of a secure environment at the place of treatment, thereby minimizing "triggering cues" for posttraumatic stress associated with persons in position of power and authority.

Treatment of PTSD in Children

The treatment of posttraumatic states in children and adolescents focuses on trauma's impact to psychological development. The primary treatment goal is to promote trauma recovery to overcome the interruption of normal development. As Table 16.1 indicates, this treatment goal is, overall, most relevant to the PTSD clusters of traumatic memory; avoidance, numbing, and denial; and interpersonal and object relations. Because of age-related factors associated with epigenetic development, the treatment of the psychobiological components of PTSD is somewhat relevant and medications may be warranted (although there is little pharmacological research with children to guide us at this time; Friedman, 2000).

Among the crucial issues in the treatment of PTSD in children is understanding the specific stage and developmental tasks which are normative in the processes of healthy maturation. Moreover, ego development is a continuous process and through it the self-structure emerges with a sense of personal identity (Wilson, 1989; Erikson, 1968). The treatment of children and adolescents with a history of trauma must be sensitive to how it has affected self-worth, self-esteem, the organization of ego states (including defenses against distressing traumatic memory), and the configuration of identity. Trauma which occurs during the formative years can cause a fracturing of the self (e.g., dissociative identity disorder) or give rise to abnormal character and personality processes that may be at least as injurious as physical damage to the body. From the point of allostasis, both physical and psychic injuries cause psychobiological alterations in organismic functioning and disrupt normal development.

Kathleen Nader presents in Chapter 12, this volume, a detailed and

comprehensive overview of treatment methods for children and adolescents with a history of trauma. Since a review of each of the alternative treatment methods (e.g., play therapy) is beyond the scope of this discussion, it is important to note that they revolve around four major themes: (1) repeated review of the event, (2) reprocessing or redefinition of memories, (3) restoration of a sense of competence and relative sense of safety, and (4) increase in sense of control. These four themes are consistent with the treatment goals for the other core therapies for PTSD listed in Table 16.1. This is not surprising since Nader reviews the alternative treatments for which there are scientific outcome data. For example, repeated review of the event is consistent with cognitive-behavioral exposure and cognitive restructuring techniques as well as approaches to dual diagnosis. The reprocessing or redefinition of memories has elements of both CBT and psychodynamic approaches. Similarly, the restoration of a sense of competence and a relative sense of safety is congruent with the objective of complex PTSD treatment. Finally, increasing a sense of self-control may be achieved by individual, family, group, or play therapies. Nevertheless, no matter which treatment options are adopted for working with children and adolescents with a history of trauma, there are recurring trends that define useful PTSD treatment:

- The child needs to feel safe, supported, and in a protected environment.
- The child must be permitted to progress in processing trauma at his or her pace. Regressions, relapses, and false gains do occur and should not be construed as failure. PTSD symptoms wax and wane over time.
- The developmental age or phase of ego development will differentially influence the impact of a given trauma. Traumatization may result in acceleration, fixation, or regression in normal development (Wilson, 1989; Erikson, 1950, 1968).
- The link between trauma and subsequent personality development is not well known. Theoretically and clinically, it is understood that trauma can alter personality characteristics in ways that give rise to developmental and personality disorders. In some exceptionally gifted individuals, trauma may give rise to psychosocial acceleration in ego processes (Wilson, 1989) or produce fractures in the self that may be expressed in art, creative endeavors, and compensatory achievement-oriented activities.
- Early trauma and victimization may make the person especially vulnerable to later interpersonal crises (Wilson, Harel, & Kahana, 1988, 1989). The issue of stress vulnerability and resiliency has become a focal point for psychoeducational interventions (Flannery, 1990) that seek to enhance resilient coping.

The long-term consequences of traumatization in childhood and adolescence are not fully understood at this time. The existing research literature suggests that there is a broad range of potential adverse outcomes. As Nader points out in Chapter 12, this volume, children improve with time and PTSD symptoms lessen. Damage to the internal organization of ego states may result in what some have termed narcissistic injury, a bruising or fracturing of the soul, or a loss of self-sameness and continuity to an individuals existence in time, space, and culture.

Treatment Approaches for Families and Couples

It is an unfortunate truism that traumatic events occur in the lives of families and couples. Individual families or couples may be involved in a life-threatening event (a motor vehicle accident, natural disaster, criminal assault, terminal illness, etc.) in which a member of the couple or family becomes afflicted with PTSD. The clinical question for the practitioner is how to best formulate a treatment plan that will assist the psychically injured client, couple or one or more members of a family.

In Table 16.1 we have stated the treatment goal for families and couples as that of restoring healthy attachments, relationships, and the capacity for intimacy. Moreover, as noted in the table and by Laurie Harkness and Nola Zador in Chapter 13, this volume, treatment typically concerns the core triad PTSD symptoms and their effects on interpersonal functioning. As these authors state: "First, the reexperiencing cluster (i.e., the disturbance in memory) *affects the survivors' ability to be present in the present.* Second, the numbing and avoidance symptoms interfere with the individual's capacity to identify, modulate, and express feelings. Third, the hyperarousal symptoms impact on the survivor's sense of safety and capacity to trust" (p. 336; emphasis added). Once present, the PTSD symptoms in a couple or family can have systemic effects, impacting the family structure, affect expression, decision making, communication patterns, and patterns of behavior and control.

In Chapter 13, Harkness and Zador suggest that once PTSD is present in a couple or family, the impact on interpersonal relations may be seen in two areas: (1) anger management and problems with aggression; and (2) tendencies toward isolation, withdrawal, and emotional detachment. Clearly, aggression and detachment reflect allostatic dysregulations of arousal and affect. On the one hand, anger and aggression are "attack" modes of dealing with conflict, distress, or other aspects of PTSD. Hyperarousal and dysregulated angry affect is behavior directed toward others in an attempt to effect emotional discharge or achieve some subjective sense of control in a situation. On the other hand, detachment is behavior that leads to tendencies to move away from others, often in an attempt to create security through actions that minimize contact or interactions with others. Avoidance in interpersonal transactions also reflects allostatic dysregulation of affect, but unlike

the attack mode of anger toward others, detachment is more likely to be associated with anxiety, fears, and thoughts of hopelessness, helplessness, and depressive psychiatric symptoms (Harkness, 1993).

In terms of treatment options, Wilson and Kurtz (1997) reviewed the various approaches from the literature on couple and marital therapies. They note that the goals of family assessment within the clinical context differ somewhat from the goals of scientific inquiry (since the objective is treatment orientation rather than research based on controlled trials). The functions of assessing PTSD in a clinical setting with families are as follows: (1) screening and initial evaluation; (2) definition of the client's problem, which may include diagnosis, labeling, or qualification of its severity; (3) planning or establishing treatment goals; and (4) monitoring treatment progress and evaluation of treatment outcome" (p. 350). In a similar vein, Harkness and Zador suggest (see Chapter 13, this volume) that while there are many models for working with PTSD in families and couples, there are several key components for successful PTSD treatment in these populations:

- Psychoeducational information about trauma, PTSD, and its effects on individuals, couples, and families
- Disclosure of the trauma story and its manifestation at the individual, dyadic, or group level
- Identification of the different ways that PTSD has impacted relationships
- Establishing boundaries and processes that facilitate safety in the context of a trusting therapeutic relationship and among dyads or family members
- Identification and screening for potential problem areas such as substance abuse, domestic violence, the presence of weapons, and homicidal and suicidal potentialities
- Assessment and identification of themes that emerge in couples/families around roles in the trauma associated with feelings of shame, guilt, responsibility, anger, blame, and areas of personal and social vulnerability
- Disclosure and working through of unintegrated traumatic material in ways that preserve couple/family unity and healthy relationships
- Assessment of the impact of trauma and its probable long-term consequences to the couple/family

As regards the final point, in some cases, as depicted in the Paramount film *Ordinary People* (1980), a family trauma may cause a split between parents and children or, in turn, lead to estrangement between partners when denial or blame override the healing forces present in the situation. Moreover, as Danieli's (1994) work has shown, traumatized families may exhibit transgenerational effects which have trajectories and consequences between and

among generations. As Harkness and Zador note in Chapter 13, some couples/families struggle with dialectical dilemmas in which "families become polarized and live parallel lives, both the family and the survivor feel alone, misunderstood, and unsupported. This polarization is a consequence of the inability to understand, integrate, appreciate, and move on beyond the dialectical dilemma" (p. 349).

It is evident that the treatment of PTSD in couples/families is a multifaceted phenomenon. Since families/couples are bonded social units, the impact of trauma is primarily to the overall stability and cohesiveness of the unit itself. What makes assessment and treatment difficult is that the traumatic event can set in motion changes in the social structure of the family. Roles, interpersonal patterns of coping with trauma, communication and decision-making processes can, and typically do, change when PTSD afflicts the heart of relational patterns. Thus, it is reasonable to speak of the treatment goal as that of restoring healthy attachments, relationships and capacity for intimacy.

Group Psychotherapy for PTSD

In group psychotherapy, there is an implicit assumption that by "being together" survivors of trauma can find opportunities to share and exchange aspects of their traumatic and life experiences with kindred souls. In the context of a group, much like that of a family, social bonds can be forged which provide avenues of friendship, trust, and opportunities for genuine self-disclosure of personal concerns. As such, group psychotherapy is a social-psychological process which is subject to the dynamics of small-group interaction. Each group is unique and defined by the personality characteristics of its members who bring their trauma histories to the group (Aronoff & Wilson, 1985). As a social process, the dynamics of the group are expectable in terms of the evolution of social structure, role differentiation, leadership, socioemotional, and task-oriented behaviors. What makes group psychotherapy unique in terms of the treatment of PTSD is that trauma survivors seek a social process in which to feel secure enough to disclose distressing and painful aspects of their trauma with others in a social milieu of trust, affiliation, commonality of experience, and a tacit knowledge that the other members understand the emotional burden of PTSD and its consequences to their lives. In that regard, the commonality of PTSD's legacy produces a trauma-response pattern which includes a "language system" between the survivor members about the psychological nuances and subtleties of their experiences. Indeed, it is common clinical knowledge that survivors have a belief (or cognitive schema) that "if you weren't there, you wouldn't understand," and are therefore reticent about disclosing information concerning the stressful experiences they endured. In a group of survivors of the same traumatic event there is a tacit understanding of the commonly shared aspects of personal problems associated with that event which facilitates communication.

Nevertheless, the group setting is an arena in which reenactments and reliving phenomena occur. Where trauma involved another person and especially the loss of another survivor during the trauma, interpersonal dynamics may get acted out with other survivors in the group in an attempt to forge closure. In an overly simplified sense, it is possible to say that group psychotherapy creates a milieu in which multiple transference projections (Wilson & Lindy, 1994) can be expressed vis-à-vis interpersonal dynamics. Moreover, as the brilliant sociologist Philip Slater (1959) observed, small groups are "microcosms of reality." In terms of the treatment of PTSD, small therapeutic groups can be microcosms of reality that not only encapsulate the emotional "tone" of individual psychic trauma but afford a means by which to examine and observe the self in the process of active enactments and reenactments of life as it was "then" (i.e., during the trauma) and as expressed "now," in day-to-day living within the group. In an existential sense (Yalom, 1985), the microcosm of the group is a mirror of the client's life and how it has shaped personality, coping with trauma and the nature of relatedness to others. In Table 16.1 we identify the treatment goal of group psychotherapy as the normalization of PTSD response and the enhanced capacity for healthy relationships.

The practitioner considering using group psychotherapy for PTSD or referring a client to a trauma-focused group, should evaluate the potential benefits and liabilities of this treatment modality. Group treatment is not for every trauma survivor, and there are practical considerations to be evaluated before encouraging a PTSD client to attend group treatment.

First of all, it is useful to consider the potential advantages of group psychotherapy that might be beneficial to healing. What is germane to the process of PTSD focal group psychotherapy? What are the social mechanisms and processes that assist group members in the processing and integration of their individual trauma history? What is it about participation in the group, as a social process, that facilitates healing? What is it about the affiliative quality of a group that helps to restore the healthy capacity to cope and relate to others in a salutary manner?

In Chapter 8, this volume, Foy et al. list five basic factors common to group psychotherapy for PTSD:

> (1) homogeneous membership in the group by survivors of the same type of trauma (e.g., combat veterans or sexual assault survivors); (2) acknowledgment and validation of the traumatic exposure; (3) normalization of traumatic responses; (4) utilization of the presence of other individuals with a similar traumatic history to dispel the notion that the therapist cannot be helpful to the survivors because he or she has not shared the experience; and (5) the adoption of a nonjudgmental stance toward behavior required for survival at the time of the trauma. Incorporating these principles facilitates the development of a psychologically safe, respectful, therapeutic environment. (p. 4)

Foy et al. note that the specific therapeutic approaches stem from different theoretical orientations, such as cognitive-behavioral, psychodynamic, supportive, or other frameworks, as to the structure and process of small group interactions for the treatment of PTSD. Furthermore, they note that there are less than 20 scientific studies of group psychotherapy outcomes, most of which provide evidence that this treatment modality is helpful to PTSD clients. But what is it about the process of involvement in group treatment for PTSD that facilitates healing?

While the available scientific data are less adequate than one would ideally prefer, clinical experience, considered together with the robust scientific literature on small-group processes (e.g., Aronoff & Wilson, 1985; Bales, 1979), provides clues as to the mechanisms in PTSD focus groups as to their therapeutic efficacy. These points are summarized as follows:

- When properly organized, based on screening for the psychological "fitness" of members, groups provide a safe place to commune with fellow survivors.
- Homogeneous trauma-focused groups enable the members to speak with each other without fear of misunderstanding or being judged by others (i.e., nonsurvivors) who do not have a psychological context by which to interpret the specifics of a person's trauma story.
- The group provides a setting for attachment, bonding, and identification with others and their emotional difficulties associated with PTSD.
- The group process encourages self-disclosure of the trauma history and PTSD's disruptive legacy to healthy psychosocial functioning. Self-disclosure has been shown to be predictive of current positive mental health status (Kahana, Harel, & Kahana, 1988; Harel, Wilson, & Kahana, 1993; Wilson, Harel, & Kahana, 1988, 1989). Self-disclosure in the context of a safe therapeutic setting contravenes stigmatization, alienation, detachment, and isolation from others.
- Participation in the group reinforces each member's personal identity as a survivor who can relate to and perceive fellow survivors as sharing a historical-cultural framework of traumatic experience (war veterans, refugees, victims of disaster or personal violence, etc.).
- The group provides a social process of acceptance and validation of the traumatic experience which is typically not available in normal transactions in society.
- Participation in the group enhances the perception of personal and social resources to aid in coping.
- Involvement in the group increases the capacity to process unassimilated traumatic memories and the capacity to find meaning in the traumatic experience and life afterward.

- The group process creates a social-psychological structure of interaction in which connection, bonding, and caring can occur within a significant community of friends and fellow survivors.
- The involvement in homogeneous groups facilitates a sense of group identity and each member's sense of self as a survivor. The sense of group identity is important (war veterans, sex abuse survivors, survivors of a school terrorist attack, etc.) because it not only validates the commonality of the experience but anchors it both contextually and sociohistorically in the life of each participant.
- A therapeutic group and involvement with others provide models of recovery, problem solving, conflict resolution, and ways of mastering maladaptive behaviors associated with PTSD. In this regard, groups provide arenas for learning alternative behaviors in terms of healthy coping and adaptation after traumatization.
- Time-limited groups encourage the participant to become proactive and take responsibility for changing maladaptive behavior. The development and initiation of proactive self-care often leads to an increase in an internal locus of control, sense of efficacy, and altruistic behaviors (Harel et al., 1993; Wilson et al., 1989; Wilson, Harel, & Kahana, 1988).

In conclusion, it may be seen that group psychotherapy is a different modality of treatment from the other 11 presented in Table 16.1. As a group process, this treatment process facilitates the normalization of PTSD as a stress response syndrome and enhances the capacity of healthy bonding, attachments, and modes of interpersonal behavior.

Severe Mental Illness and PTSD Treatment

The severe mental illnesses (SMI) such as schizophrenia, major depression, delusional disorders, psychotic disorders, and bipolar disorders have been the traditional province of modern psychiatry. The complexity of severe mental illness gave rise to nosological systems of classification and scientific studies of their etiology and pathological sequelae. As noted by Kim T. Mueser and Stanley D. Rosenberg in Chapter 14, this volume, recent epidemiological and national comorbidity studies have discovered that lifetime exposure to a traumatic event is quite prevalent in U.S. society, with population estimates ranging between 39% and 56%. Thus, the question naturally arises as to the relationship between trauma exposure and the development of SMI. Further, if there is a correlation between trauma exposure and SMI, is there also a relationship between SMI and PTSD in the history of the patient's illness?

In terms of an operational definition of SMI, Mueser and Rosenberg (Chapter 14) define the condition as follows:

> Severe mental illness is a general term used to describe individuals with psychiatric disorders that have a profound impact on functioning in a wide range of domains, such as the ability to work, to care for oneself and live independently in the community, and to maintain rewarding interpersonal relationship. . . . Psychotic symptoms such as hallucinations or delusions are common but not universal in this population. Due to their difficulties working and living independently in the community, patients with SMI frequently receive disability income, such as Social Security Disability Income (SSDI) or Social Security Supplemental Income (SSSI)." (p. 356)

In the simplest formulations then, SMI is associated with impairment in functioning, a fact well known to practitioners who work with such patients. But what if the person with SMI also has a history of trauma and the symptoms of PTSD? As Mueser and Rosenberg note, "only three studies have examined PTSD in patients with SMI, but each study suggests notably higher rates of PTSD" (Chapter 14, p. 358). Moreover, the results of these studies revealed that PTSD was not only underdiagnosed in SMI patients but their clinical records lacked information as to the specificity of their trauma histories and lacked diagnostic codes for PTSD. Clearly, the underdiagnoses and infrequent documentation trauma histories, as well as lack of a DSM-IV diagnosis (of 309.81) for the PTSD, had treatment implications. Most notably was the tendency to focus on the SMI and not to explore the patient's trauma history and PTSD symptomatology. As noted earlier in this chapter, dual diagnosis is not uncommon in PTSD, especially major depression and substance abuse. However, in the case of SMI, it is as if the patient's clinical status is being viewed through the "lens" of SMI rather than focusing the lens more carefully to sharpen the resolution enough to "see" PTSD and its relation to SMI. Mueser and Rosenberg in Chapter 14 hypothesize as follows:

> PTSD is mainly responsible for the relationship between trauma and more severe clinical presentation in patients with SMI. PTSD is given a central mediating role in this model because the symptoms which define PTSD, as well as its common clinical correlations, can be theoretically linked to a worse prognosis of SMI. PTSD is hypothesized to both directly and indirectly increase symptom severity and risk of relapse in patients with SMI. PTSD can directly affect SMI through increased avoidance behavior, distress related to reexperiencing the trauma, and physiological overarousal. Common correlates of PTSD can also indirectly affect SMI, including retraumatization, a poor working alliance, and substance abuse. (pp. 360–361)

The treatment of patients with SMI and PTSD is at least as complex and difficult as that reviewed for dual diagnosis and complex PTSD. The combination of PTSD and SMI presents a challenge to practitioners because

of the severity of the psychiatric disorder and the manner in which PTSD overlaps with some of the symptoms of SMI (e.g., hallucinations, intrusive thoughts, images and feelings; suspicion, doubt, mistrust, guardedness; reticence of self-disclosure; secretiveness; depressive vegetative symptoms; and hyperarousal states with emotional lability; see Chapter 2 for a discussion of the 65 PTSD symptoms in the core five dimensions derived from the allostatic tetrahedral model). Moreover, not only is there the possibility of SMI/PTSD symptom overlap, but as Mueser and Rosenberg note, PTSD mediates and to some extent "drives" SMI behavioral manifestations.

At present there are not enough scientifically controlled studies of SMI/PTSD treatment. Mueser and Rosenberg suggest some practical guidelines for practitioners and those working in institutional settings with PTSD embedded within SMI.

- Combined treatment approaches for SMI and PTSD are useful. As with other PTSD comorbidity approaches, SMI/PTSD requires a formulation as to how to address the multilayered complexity of the patient with a history of trauma, PTSD, and the development of SMI.
- The timing and phasing of PTSD therapy using cognitive-behavioral, pharmacological, or psychodynamic core PTSD treatments requires (1) careful assessment of the patient's mental status, (2) his or her capacity to tolerate a core PTSD treatment, and (3) the risk of SMI by exposure of the trauma material.
- Psychoeducation and support for the activities of daily living is crucial to contravene the debilitating symptoms of SMI.
- The routine case management of a patient should include a comprehensive trauma history, adequate psychological and psychometric assessment, and proper charting of the history and PTSD diagnosis in the file.
- Service provision requires carefully coordinated cooperation between mental health providers in order to match the needed services to the patient's needs so as to achieve optimal rehabilitation strategies.
- Given the complexity of SMI/PTSD, long-term care is likely, and it is expectable that relapse, episodic manifestations of PTSD, and chronicity of SMI will occur.
- Standardization yet flexible interventions for SMI/PTSD need to be developed, evaluated, and subjected to scientific study as part of comprehensive rehabilitation—treatment programs.

In conclusion, Table 16.1 indicates that the primary treatment goal for SMI and PTSD is social reintegration and support for the activities of daily living.

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